DWC
Division of Workers' Compensation
Texas Department of Insurance

TDI-DWC Forms used by Designated Doctors

1. DWC Form-032, *Request for Designated Doctor Examination*
2. DD-01-TM-11, Designated Doctor Selection Response
3. OA32O, Division Ordered Designated Doctor Exam
4. HRG-04-TM-04, *Presiding Officer's Directive to Order DD Exam*
5. DWC Form-067, *Designated Doctor Certification Application*
6. DWC Form-068, *Designated Doctor Examination Data Report*
7. DWC Form-069, *Report of Medical Evaluation* (01/15)
8. DWC Form-073, *Work Status Report*

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645
(512) 804-4380 phone • (512) 804-4121 fax

Complete, if known:
DWC Claim #
Carrier Claim #

Request for Designated Doctor Examination

Type (or print in black ink) each item on this form

I. INJURED EMPLOYEE INFORMATION

1. Employee Name (First, Middle, Last)	**2. Employee Social Security Number**
3. Employee Address (Street or P.O. Box, City, State, Zip Code)	**4. Employee County**
5. Employee Primary Phone Number ( )	**6. Employee Alternate Phone Number** ( )
7. Employee Date of Birth (mm-dd-yyyy)	**8. Date of Injury** (mm-dd-yyyy)

II. EMPLOYER INFORMATION *(at the time of injury)*

9. Employer Name	**10. Employer Phone Number** ( )
11. Employer Address (Street or P.O. Box, City, State, Zip Code)	

III. INSURANCE CARRIER INFORMATION

12. Insurance Carrier Name	
13. Insurance Carrier Address (Street or P.O. Box, City, State, Zip Code)	
14. Adjuster Name (First, Middle, Last)	**15. Adjuster E-mail Address**
16. Adjuster Phone Number ( )	**17. Adjuster Fax Number** ( )
Only Insurance Carriers Complete Boxes 18 - 22	
18. Insurance Carrier's Authorized Agent Company Name	
19. Insurance Carrier's Bill Review Agent Name	
20. Bill Review Agent Address (Street or P.O. Box, City, State, Zip Code)	
21. Bill Review Agent Phone Number ( )	**22. Bill Review Agent Fax Number** ( )

IV. INJURED EMPLOYEE REPRESENTATIVE INFORMATION *(if any)*

23. Representative's Name (First, Middle, Last)	**24. Representative's Phone Number** ( )
25. Representative's E-mail Address	**26. Representative's Fax Number** ( )

For TDI-DWC Use Only

V. TREATING DOCTOR INFORMATION

27. Treating Doctor Name	**28. Treating Doctor Phone Number** ( )
29. Treating Doctor Address (Street or P.O. Box, City, State, Zip Code)	**30. Treating Doctor Fax Number** ( )
31. Treating Doctor License Number	**32.Treating Doctor License Type**

VI. DESIGNATED DOCTOR SELECTION INFORMATION

33. Does the claim involve medical benefits provided through a Certified Workers' Compensation Health Care Network? ☐ Yes ☐ No If yes, provide the name of the network.

34. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? ☐ Yes ☐ No
If yes, provide the name of the health care plan.

35. Check all body parts and diagnoses that apply:	**Examples (not an exhaustive list)**
☐ Spine and Torso	Cervical, Thoracic, Lumbar, Sacroiliac, Sacrum, Coccyx, Pelvis, Sternum and Manubrium, Rib Cage, Chest Wall, Abdominal Wall
☐ Upper Extremities	Shoulder including Glenohumeral and Acromioclavicular Joints, Clavicle, Sternoclavicular Joint, Scapula, Forearm, Arm, Elbow, Wrist, Hand, Finger
☐ Lower Extremities (excluding feet)	Hip, Buttock, Thigh, Leg, Knee
☐ Feet	Foot, Heel, Toe
☐ Teeth and Jaw	Tooth, Jaw, Temporomandibular Joint (TMJ)
☐ Eyes	Eye, Eyelid
☐ Other Body Areas or Systems	Internal Systems; Ear, Nose, and Throat; Head and Face; Skin; Mental and Behavioral Disorders; Tendon Lacerations; Dislocations
☐ Traumatic Brain Injury	N/A
☐ Spinal Cord Injuries	Spinal cord injuries, including spinal fractures with documented neurological deficit
☐ Severe Burns (including chemical burns)	3rd or 4th degree over 9% or greater of the body
☐ Multiple Bone Fractures (excluding spinal fractures)	N/A
☐ Infectious Diseases (complicated)	Infection requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens
☐ Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)	N/A
☐ Chemical Exposure (excluding chemical exposure limited to skin exposure)	N/A
☐ Heart or Cardiovascular Condition	N/A

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

VII. EXAMINATION / INJURY INFORMATION

36. Provide the specific reason(s) for the requested examination. The reason(s) must indicate how the examination will resolve a dispute or assist in the progression of the claim.

37. List all injuries determined to be compensable by TDI-DWC or accepted as compensable by the insurance carrier. (If using ICD codes, you must also provide descriptions.)

38. Has a previous designated doctor examination been performed for this claim?
☐ Yes ☐ No If No, skip boxes 39 - 41.

39. Regarding the most recent designated doctor examination, provide the following information:

a. Name of the designated doctor

b. Date of the examination (mm/dd/yyyy)

40. If approval of this request would result in the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) scheduling an examination within 60 days of a previous designated doctor examination, provide good cause as to why it is necessary to schedule this examination within 60 days.

41. Explain any change of medical condition since the most recent designated doctor examination.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

VIII. PURPOSE FOR EXAMINATION

42. Requester: For items A through G below, check the box(es) next to the issue(s) you want the designated doctor to address and provide the requested information.
Designated Doctor: Address only the issues that are checked. If Box A or B is checked, you must file the DWC Form-069. If Box E or F is checked, you must file the DWC Form-073. If Box C, D or G is checked, you must file the DWC Form-068.

☐ **A. Maximum Medical Improvement (MMI)**

Statutory MMI Date (if any) _____ (mm/dd/yyyy)

Questions for the Designated Doctor to consider in the examination:
Has MMI been reached; if so, on what date (may not be greater than the statutory MMI date shown above)?

☐ **B. Impairment Rating (IR)**

MMI Date* (required only if Box A is not checked) _____ (mm/dd/yyyy)

*The MMI date that has been determined to be valid by a final decision of the TDI-DWC or court or by agreement of the parties.

Question for the Designated Doctor to consider in the examination: As of the MMI date, what is the IR?

☐ **C. Extent of Injury**

List all injuries (diagnoses/body parts/conditions) in question, claimed to be caused by, or naturally resulting from the accident or incident.

Describe the accident or incident that caused the claimed injury.

Question for the Designated Doctor to consider in the examination: Was the accident or incident giving rise to the compensable injury a substantial factor in bringing about the additional claimed injuries or conditions, and without it, the additional injuries or conditions would not have occurred? Include an explanation of the basis for your opinion.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

☐ **D. Disability – Direct Result** (check only if the injured employee is unable to obtain and retain employment at wages equivalent to the pre-injury wage)

Provide the beginning and ending* dates for the claimed periods of disability. If multiple periods, list all dates.
From _____ to _____ (mm/dd/yyyy)

*The ending date cannot be a future date. You may enter "present" for the ending date.

Question for the Designated Doctor to consider in the examination: Is the employee's inability to obtain and retain employment at wages equivalent to the pre-injury wage a direct result of the compensable injury?

☐ **E. Return to Work**

Provide the beginning and ending dates for each period covered by this request only if you are requesting the designated doctor to examine the injured employee's work status for a time other than the present. If multiple periods, list all dates.

From _____ to _____ (mm/dd/yyyy)

Questions for the Designated Doctor to consider in the examination:
Is the injured employee able to return to work in any capacity and what work activities can the injured employee perform?

☐ **F. Return to Work (Supplemental Income Benefits)**

Provide the beginning and ending dates for each qualifying period covered by this request. If multiple periods, list all dates. From _____ to _____ (mm/dd/yyyy)

Is the above qualifying period(s) applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? ☐ Yes ☐ No

NOTE: Injured employees are allowed only one designated doctor examination per year after the second anniversary (8th quarter) of Supplemental Income Benefits.

Question for the Designated Doctor to consider in the examination: Has the injured employee's medical condition improved sufficiently to allow the employee to return to work in any capacity for the identified qualifying period(s)?

☐ **G. Other Similar Issues**

Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s).

NOTE: Designated Doctor examinations **may not** be requested for developing treatment plans, determining appropriateness of medical care, or determining compensability.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

IX. REQUESTER CERTIFICATION

43. Check the appropriate box:

☐ **Injured Employee** ☐ **Injured Employee Representative** ☐ **Insurance Carrier** ☐ **TDI-DWC**

I certify the following:

- I am authorized to request the examination;
- All the information provided on this form is true and correct; and
- I provided a copy of this request to all parties at the time the original request was submitted to TDI-DWC.

I understand that any misstatement, falsification, or omission could cause an incorrect selection of the designated doctor and may result in the TDI-DWC voiding any order issued pursuant to the request or taking enforcement action, including administrative penalties and/or fines.

If "insurance carrier" is checked above, I further certify the following:
I have been authorized by the insurance carrier to provide employees of the company named in Section III, Box 18, with the insurance carrier's authorization to take all further actions and communicate with the TDI-DWC regarding this DWC Form-032 *Request for Designated Doctor Examination.* Inquiries may be made in order to:

- check the status of the request;
- inquire about the reason the request was denied;
- inquire about information for the scheduled examination; and
- inquire about any other information related to the request for the examination.

44. Signature of Requester	
45. Printed Name of Requester	**46. Date of Signature** (mm/dd/yyyy)

Employee's Name: DWC Claim Number:	For TDI-DWC Use Only

Frequently Asked Questions
Request for Designated Doctor Examination (DWC Form-032)

Who may request that a designated doctor examination be ordered?
The injured employee, the injured employee's representative, or the insurance carrier may request the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to order a designated doctor examination. The TDI-DWC may also order a designated doctor examination on its own motion.

How often can a designated doctor examination be performed?
Prior to Supplemental Income Benefits (SIBs) eligibility and during the first eight quarters of receiving SIBs, a designated doctor examination may not be performed more than once every 60 days. The TDI-DWC may approve additional requests for an examination within the 60-day period if good cause exists. After eight quarters of SIBs, a designated doctor examination may be performed no more than once per year.

Do I have to complete all the fields on the DWC Form-032?
Failure to provide all required information on the DWC Form-032 may cause a delay in processing and your request may be returned to you.

If the injured employee does not have a treating doctor, you must specify *"No Treating Doctor"* in the space provided for the treating doctor's name in Box 27. If any other requested information is not applicable, answer "N/A".

Where do I file the DWC Form-032?
You are ***required to provide a copy of the completed DWC Form-032 to all parties*** at the time you submit the original request to the TDI-DWC. Submit the completed form to TDI-DWC by fax to (512) 804-4121 or by mail to the address shown below.

Texas Department of Insurance
Division of Workers' Compensation
Designated Doctor Examination Request Processing & Monitoring
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645

What does TDI-DWC do?
If the request is approved, the TDI-DWC assigns a qualified designated doctor to examine the injured employee. If there is a designated doctor who was previously assigned to the claim, the same doctor will be used as long as the doctor is still qualified and available. If the request is approved, within 10 days the TDI-DWC will issue an order to the parties regarding the examination. If the request is denied, you will receive a notice providing you with the specific reason(s) for the denial.

If you wish to dispute the TDI-DWC's approval or denial of a *Request for Designated Doctor Examination*, you are entitled to seek an expedited Contested Case Hearing under 28 Texas Administrative Code §140.3.

Where do I find more information on the designated doctor process?
For more information contact your local TDI-DWC Field Office at 1-800-252-7031. Additional resources that answer common questions about the designated doctor process are also available on the TDI website at http://www.tdi.texas.gov/wc/hcprovider/dd.html.

NOTE[1]: Title 28 Texas Administrative Code §127.1(b) (9) requires that in order to request a designated doctor examination, a request must be submitted on the form prescribed by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Dr. Ste 100 □ Austin, Texas 78744-1609
(512) 804-4380 □ Fax (512) 490-1049 □ www.tdi.state.tx.us

For TDI-DWC Office Use		
ACS ID Number	DWC Form-032(s) Faxed by:_____ Fax date:_____	Appt. Entered by:_____ date:_____

Designated Doctor Appointment Selection Response Form

Date:

Designated Doctor Contact Information		TDI-DWC Staff Contact Information	
To:	Appointment Scheduler	From:	DD Scheduling
Telephone Number:		Telephone Number:	(512) 804-4380
Fax Number:		Fax Number:	(512) 490-1049
License Type/Number:		DWC Field Office:	
Designated Doctor:		Field Office County:	

Appointment Requirements	
Timeframe	**Examination Address**
#Error	

TDI recommends appointments scheduled 30 minutes apart and consideration of Holidays when selecting dates / times.

Injured Employee(s)	DWC Number	WC Network Information		Appointment	
		Injured Employee's WC Network	Is DD in same WC Network?	Date	Time
1					
2					
3					
4					
5					

Designated Doctor/Agent's Response and Verification

Initial Here	I do not have any disqualifying associations as described in 28 TAC §180.21 which includes a contract with the same WC health care network, if any, that is responsible for the provision of medical benefits to the injured employee name above
	I understand the examination address indicated above may not be changed by any party or by an agreement of any parties without good cause and the approval of the division [28 TAC §127.5 (b)].

Comments

Printed Name and Signature of Person Completing Form	Telephone Number	Date

Coordination Requirements:
Your response is due by 5:00 P.M. of the next bussiness day from the receipt of this notice. You must fax your response to TDI-DWC @ (512) 490-1049.

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Dr., Ste 100
Austin, TX 78744-1645

Injured Employee:
DWC #:
Date of Injury:
Employer:
Carrier:
Carrier Claim #:
Date:

Subject Considered:
REQUEST FOR DESIGNATED DOCTOR EXAMINATION

COMMISSIONER ORDER

DIVISION ORDERED DESIGNATED DOCTOR EXAMINATION

Designated Doctor Examination Information	**Purpose of Examination**
Designated Doctor: License Number: Telephone Number: Examination Date: Examination Time: Examination Location*:	☐ Maximum Medical Improvement (MMI) ☐ Impairment Rating (IR) ☐ Extent of Injury (for the injuries specified in Section V of the Directive) ☐ Disability ☐ Return to Work ☐ Return to Work (Supplemental Income Benefits) ☐ Other (Similar Issues): _____ as specified by the Presiding Officer's Directive to Order a Designated Doctor Examination.
***NOTE TO TREATING DOCTOR AND INSURANCE CARRIER** Send medical records to designated doctor's correspondence address at	

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has issued a Presiding Officer's Directive to Order a Designated Doctor Examination.

IT IS THEREFORE ORDERED by the Commissioner of Workers' Compensation that parties named in this Order comply with the terms as specified below. The examination conducted pursuant to this Order and all reports and communication that result from this Order shall comply with applicable TDI-DWC rules and provisions of the Texas Labor Code. Failure or refusal by any person to comply with this Order is an administrative violation and may subject the person to sanctions as authorized by the Texas Labor Code or TDI-DWC rules.

IT IS FURTHER ORDERED THAT THE INJURED EMPLOYEE NAMED ABOVE SHALL attend the examination specified in this Order. The name and telephone number of the designated doctor assigned in accordance with Texas Labor Code §408.0041 are listed in Section I above. The examination date, time, and location are shown above. The examination location may not be changed without prior approval of the TDI-DWC. If the injured employee fails or refuses to attend this examination without good cause, the insurance carrier may suspend payment of income benefits. If a scheduling conflict prevents the injured employee from attending the examination as scheduled, the injured employee must reschedule the examination by calling the designated doctor at least one (1) working day prior to the scheduled examination. A rescheduled examination must occur within 21 calendar days of the originally scheduled examination.

IT IS FURTHER ORDERED THAT THE DESIGNATED DOCTOR NAMED ABOVE SHALL perform the examination of this injured employee at the examination location and on the date and time shown above. The examination location may not be changed without good cause and the prior approval of the TDI-DWC. If a scheduling conflict prevents the designated doctor from attending the examination as scheduled, the designated doctor must reschedule the examination by calling the injured employee at least 24 hours prior to the scheduled examination. A rescheduled examination shall be set to occur no later than 21 calendar days after the originally scheduled examination and may not be rescheduled to occur before the originally scheduled examination. If the designated doctor has not received medical records at least three (3) working days prior to the examination, the designated doctor shall not conduct an examination and shall report this violation to the TDI-DWC within one (1) working day of not timely receiving the records. Once notified, the TDI-DWC shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one (1) working day of the examination or if the designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records. If the injured employee qualifies for accommodations under Title II of the *American with Disabilities Act*, the designated doctor will communicate with the insurance carrier to assure that appropriate accommodations are provided at the time of the examination.

To determine the existence and degree of the injured employee's impairment, the designated doctor must use the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Fourth Edition, (1st, 2nd, 3rd, or 4th printing), including corrections and changes as issued by the AMA prior to May 16, 2000. The designated doctor must use the DWC Form-069, *Report of Medical Evaluation*, to report findings and submit the form and documentation supporting the calculation of the impairment rating to the injured employee, injured employee's representative, if any, treating doctor, insurance carrier, and the TDI-DWC no later than seven (7) working days after the examination. 28 Texas Administrative Code (TAC) §§127.10(d), 127.220(b) and 130.3 are applicable to this examination.

IT IS FURTHER ORDERED THAT THE TREATING DOCTOR, IF ANY, SHALL send a copy of all medical records related to the injured employee's medical condition to the designated doctor at the correspondence address provided on this Order. The treating doctor may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities. The analysis must comply with 28 TAC §127.10(a)(2). If the treating doctor sends an analysis to the designated doctor, the treating doctor must also send a copy to the insurance carrier, injured employee, and injured employee's representative, if any. The treating doctor shall ensure that the required records and analyses, if any, are received by the designated doctor no later than three (3) working days prior to the examination. The analysis sent by any party may only cover the injured employee's medical condition, functional capabilities, and return-to-work opportunities as provided in Texas Labor Code §408.0041.

IT IS FURTHER ORDERED THAT THE INSURANCE CARRIER NAMED ABOVE SHALL send a copy of all medical records related to the injured employee's medical condition to the designated doctor at the correspondence address provided on this Order. The insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities. The analysis must comply with 28 TAC §127.10(a)(2). If an analysis is sent to the designated doctor, a copy must also be sent to the treating doctor, injured employee, and injured employee's representative, if any. The insurance carrier must ensure that the required records and analysis, if any, are received by the designated doctor no later than three (3) working days prior to the examination. Texas Labor Code §408.0041(h) requires the insurance carrier to pay for the designated doctor's service. If the injured employee qualifies for accommodations under Title II of the Americans with Disabilities Act, the insurance carrier shall communicate with the designated doctor to ensure that those accommodations are in place for the examination. The analysis sent by any party may only cover the injured employee's medical condition, functional capabilities, and return-to-work opportunities as provided in Texas Labor Code §408.0041.

NOTICE TO DOCTORS AND HEALTH CARE PRACTITIONERS: Your financial interests, as a health care practitioner, in a health care provider including a health care facility are required to be disclosed in accordance with Texas Labor Code §413.041 and 28 TAC §§127.140 and 180.24 when you have made a referral to such a health care provider. To submit information, go to the TXCOMP Health Care Provider System at http://www.tdi.texas.gov/wc/txcomp.html.

NOTICE TO ALL PARTIES: This examination is authorized by Order of the Commissioner of Workers' Compensation and may not be canceled except by Order of the Commissioner. Parties are entitled to file a request for an expedited contested case hearing to dispute an approved request for Designated Doctor Examination. Parties seeking expedited proceedings and the stay of an ordered examination must file their request for expedited proceedings with the TDI-DWC within three (3) days of receiving this order [28 TAC §127.1(f)]. A copy of the DWC Form-032 filed to request this examination is available by contacting the TDI-DWC at 1-800-252-7031 to obtain a copy.

NOTICE TO INJURED EMPLOYEE: Texas Labor Code §408.0041(h)(2) says the insurance carrier shall pay for reasonable expenses incident to the employee in attending the examination. A travel reimbursement form may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20.html or by calling 1-800-252-7031. An injured employee who qualifies has the right to receive appropriate accommodations under Title II of the Americans with Disabilities Act.

Sherry Brunson
Director of Records Management and Support
Designated Doctor Examination Coordination

C:

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645
(512) 804-4010 phone • (512) 804-4011 fax

Presiding Officer's Directive to Order Designated Doctor Exam

I. Injured Employee Information

Employee Name	Employee Address	
Exam Type ☑ Initial ☐ Re-Exam	DWC #	Employee SSN
Date of Birth	Date of Injury	Telephone Number

Does the claim involve medical benefits provided through a Certified Workers' Compensation Health Care Network or a political subdivision pursuant to 504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? ☐ Yes ☑ No
If Yes, name of network or health care plan:

II. Other Contact Information

			Phone Number	Fax Number
Employee Representative or Assistant (OIEC) Name				
Insurance Carrier/Adjuster Name				
Treating Doctor Name	License Number	License Type		

III. Reason for Exam (See Page 2, *Section V. regarding Presiding Officer's Specific Instructions for Examination*)

	Reason (check all that apply)	Additional Information
☐	A. Maximum Medical Improvement	Statutory MMI Date (if any): (mm/dd/yyyy)
☐	B. Impairment Rating	MMI Date (Only if Box A of this section is Not Checked): (mm/dd/yyyy)
☐	C. Extent of Injury	Specific information should be included in Section V of this directive (page 2)
☐	D. Disability – Direct Result	Period to be assessed: From: to (mm/dd/yyyy) Ending date cannot be a future date. You may enter "present" for the ending date.
☐	E. Return to Work	Period to be assessed: From: to (mm/dd/yyyy)
☐	F. Return to Work (Supplemental Income Benefits)	Period to be assessed: From: to (mm/dd/yyyy) Is the above qualifying period applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? ☐ Yes ☐ No
☐	G. Other similar issues	Specific information should be included in Section V of this directive (page 2)

IV. Body Areas/Diagnoses to be Assessed by the Designated Doctor

If re-examination, should a new Designated Doctor be assigned? ☐ Yes ☐ No Current DD

☐	Spine and Torso	☐	Spinal Cord Injuries
☐	Upper Extremities	☐	Severe Burns (including chemical burns)
☐	Lower Extremities (excluding feet)	☐	Multiple Bone Fractures (excluding spinal fractures)
☐	Feet	☐	Infectious Diseases (complicated)
☐	Teeth and Jaw	☐	Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
☐	Eyes	☐	Chemical Exposure (excluding chemical exposure limited to skin exposure)
☐	Other Body Areas/Systems	☐	Heart or Cardiovascular Condition
☐	Traumatic Brain Injury		

Employee Name	DWC #	Employee SSN	Date of Birth	Date of Injury

V. Presiding Officer's Specific Instructions for Examination

Presiding Officer (Printed Name)	Signature	Date

TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
512-804-4766 | F: 512-804-4207 | TDI.texas.gov | @TexasTDI

DESIGNATED DOCTOR CERTIFICATION APPLICATION

☐ Initial Certification
☐ Recertification

Date current certification expires, if applicable

_____(mm/yyyy)

I. APPLICANT / INDIVIDUAL INFORMATION (not administrative services company/agent information)

1. Name (Last, First, Middle, Suffix)	**2. Social Security Number**	**3. Date of Birth** (mm/dd/yyyy)
4. Home Mailing Address (Street or PO Box, City, State, ZIP Code)		
5. Business Mailing Address (Street or PO Box, City, State, ZIP Code)		
6. Home Phone Number ( )	**7. Business Phone Number** ( )	**8. Cell Phone Number** ( )
9. Fax Number ( )	**10. E-mail Address**	
11a. Non-English Language Spoken by Applicant ☐ Yes ☐ No If yes, specify	**11b. Non-English Language Spoken by Office Personnel** ☐ Yes ☐ No If yes, specify	

II. LICENSE INFORMATION (attach additional pages, if necessary)

Texas License	Other License (if applicable)	Other License (if applicable)
12. License Type	**17. License Type**	**22. License Type**
13. License Number	**18. License Number**	**23. License Number**
14. State of Registration Texas	**19. State of Registration**	**24. State of Registration**
15. Original Date of Issue (mm/yyyy)	**20. Original Date of Issue** (mm/yyyy)	**25. Original Date of Issue** (mm/yyyy)
16. Expiration Date (mm/yyyy)	**21. Expiration Date** (mm/yyyy)	**26. Expiration Date** (mm/yyyy)

For TDI-DWC Use Only

III. PROFESSIONAL SPECIALTY INFORMATION - MD/DO ONLY (attach additional pages, if necessary)

List professional specialties	Provide the applicable dates (mm/yyyy)
27. Primary Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:
28. Secondary Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:
29. Additional Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:
NOTE: The applicant may be required to present ABMS or AOABOS documentation for verification purposes.	

IV. EDUCATION (attach additional pages, if necessary)

30. Professional Degree ☐ Medical/Osteopathic ☐ Chiropractic ☐ Optometry ☐ Podiatry ☐ Dentistry		
31. Institution	**32. Degree**	**33. Attendance Dates** (mm/yyyy) From to
34. Address (Street or PO Box, City, State, ZIP Code)		
35. Post-Graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	**36. Program Director**	**37. Current Program Director** (if known)
38. Institution	**39. Program Specialty**	**40. Attendance Dates** (mm/yyyy) From to
41. Address (Street or PO Box, City, State, ZIP Code)		**42. Program Completed Successfully** ☐ Yes ☐ No
43. Post-Graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	**44. Program Director**	**45. Current Program Director** (if known)
46. Institution	**47. Program Specialty**	**48. Attendance Dates** (mm/yyyy) From to
49. Address (Street or PO Box, City, State, ZIP Code)		**50. Program Completed Successfully** ☐ Yes ☐ No
51. Other Graduate-Level Education (field of study)		
52. Institution	**53. Degree**	**54. Attendance Dates** (mm/yyyy) From to
55. Address (Street or PO Box, City, State, ZIP Code)		

Applicant's Name: Texas License #:	For TDI-DWC Use Only

V. ACTIVE PRACTICE / WORK HISTORY INFORMATION

Active Practice
56. Have you maintained an active practice* for at least 3 years? ☐ Yes ☐ No * Active practice is defined as maintaining routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients.

Work History (attach additional pages, if necessary)	
57. Current Practice / Employer Name (if any)	**58. Start Date / End Date** (mm/yyyy) From to
59. Address (Street or PO Box, City, State, ZIP Code)	
60. Previous Practice / Employer Name	**61. Start Date / End Date** (mm/yyyy) From to
62. Address (Street or PO Box, City, State, ZIP Code)	
63. Previous Practice / Employer Name	**64. Start Date / End Date** (mm/yyyy) From to
65. Address (Street or PO Box, City, State, ZIP Code)	
66. Previous Practice / Employer Name	**67. Start Date / End Date** (mm/yyyy) From to
68. Address (Street or PO Box, City, State, ZIP Code)	

VI. WORKERS' COMPENSATION HEALTH CARE NETWORK AFFILIATIONS

List all current workers' compensation health care network (network) affiliation(s) pursuant to Insurance Code §1305 and affiliation(s) with political subdivision health care plan(s) pursuant to Texas Labor Code §504.053(b)(2). Enter the contract start date for each network and each health care plan. (attach additional pages, if necessary)	
69. Network / Health Care Plan Name	**70. Start Date** (mm/dd/yyyy)
71. Network / Health Care Plan Name	**72. Start Date** (mm/dd/yyyy)
73. Network / Health Care Plan Name	**74. Start Date** (mm/dd/yyyy)

VII. ADMINISTRATIVE SERVICES COMPANY / BILLING AGENT / OTHER AGENT AFFILIATIONS

List all current administrative services company, billing agent, and other agent affiliation(s) (attach additional pages, if necessary)	
75. Administrative Services Company / Agent Name	**76. Contract Start Date** (mm/dd/yyyy)
77. Administrative Services Company / Agent Address (Street or PO Box, City, State, ZIP Code)	
78. Name of Point of Contact	**79. Phone Number of Point of Contact** ( )
80. E-mail Address of Point of Contact	**81. Fax Number of Point of Contact** ( )
82. Billing Agent Name	**83. Billing Agent Phone Number** ( )

Applicant's Name: Texas License #:	For TDI-DWC Use Only

VIII. **DISCLOSURE QUESTIONS** (check **YES** or **NO** for each question)

84. *Licensure*	YES	NO
Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, disciplinary action, remedial plan, probation or any conditions or limitations by any state licensing board or state or federal agency, including TDI-DWC?	☐	☐
Has you or your professional practice ever received a reprimand or been fined by any state licensing board or state or federal agency, including TDI-DWC?	☐	☐
85. *Hospital Privileges and Other Affiliations*	**YES**	**NO**
Have your clinical privileges or medical staff membership at any hospital or health care institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board?	☐	☐
Have you ever voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐	☐
Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐	☐
86. *Education, Training and Board Certification*	**YES**	**NO**
Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	☐	☐
Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐	☐
Have any of your board certifications or eligibility ever been revoked?	☐	☐
Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐	☐
87. *DEA (Drug Enforcement Administration) or DPS (Department of Public Safety)*	**YES**	**NO**
Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐	☐
88. *Medicare, Medicaid or other Governmental Program Participation*	**YES**	**NO**
Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐	☐
Other sanctions or investigations?	☐	☐
Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	☐	☐
To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐	☐
Have you ever received sanctions from or been the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?	☐	☐

Applicant's Name:

Texas License #:

For TDI-DWC Use Only

Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency?	☐	☐
Have you ever been terminated or resigned while under investigation by a hospital or health care facility of any military agency?	☐	☐
89. *Malpractice Claims History*	**YES**	**NO**
Have you had any active/pending malpractice claims/actions at any time during the past 5 years?	☐	☐
90. *Criminal*	**YES**	**NO**
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	☐	☐
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony including an act of violence, child abuse or a sexual offense?	☐	☐
Have you ever been court-martialed for actions related to your duties as a medical professional?	☐	☐
91. *Ability to Perform Job*	**YES**	**NO**
Are you currently engaged in the illegal use of drugs? NOTE: "Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice one's profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. §812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.	☐	☐
Do you use any chemical substances that would in any way impair or limit your ability to practice your profession and perform the functions of your job with reasonable skill and safety?	☐	☐
Do you have any reason to believe that you would pose a risk to the safety or well-being of injured employees or other system participants?	☐	☐
Are you unable to perform the essential functions of a designated doctor as specified in 28 Texas Administrative Code, Chapter 127 and other applicable provisions of TDI-DWC rules and the Texas Labor Code?	☐	☐
92. *Disclosure Explanations* (attach additional pages, if necessary)		
If you answered "Yes" to any question(s), identify each question by number and explain below.		

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information TDI-DWC collects about you; get and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.

Applicant's Name:

Texas License #:

For TDI-DWC Use Only

IX. APPLICANT'S AUTHORIZATION, ATTESTATION AND RELEASE

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in, or with, the TDI-DWC. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I certify that all information provided in this application is true, complete, and correct to the best of my knowledge. I understand that I am required on my own initiative to report to the TDI-DWC any updated information within 10 working days of a change in any of the information provided to the division on the doctor's application for certification or recertification as a designated doctor.

I am aware that participation in the Texas workers' compensation system as a designated doctor is not a right and is conditioned upon compliance with Title 5 of the Labor Code and TDI-DWC rules and my provision of quality health care, evaluations, and/or medical opinions.

I affirm that I will remain aware of and in compliance with the requirements of the statutes and TDI-DWC rules, including but not limited to:

- financial disclosure requirements as contained in the Labor Code §413.041;
- cooperating with TDI-DWC monitoring and review efforts such as audits by the TDI-DWC;
- paying audit bills when required by statute or rule;
- providing updated information under TDI-DWC rules §127.200(a)(8);
- consenting to any on-site inspections consistent with TDI-DWC rules §127.200(a)(15); and
- owning or maintaining subscriptions to the current editions of guidelines adopted by the TDI-DWC, including impairment rating, treatment, and return-to-work guidelines.

I understand and agree that any material misstatement or omission in the application may result in delay, denial, revocation, and/or immediate suspension or termination of certification.

93. Signature of Applicant	
94. Printed Name of Applicant	**95. Date of Signature** (mm/dd/yyyy)

X. SUBMISSION INSTRUCTIONS

96. Check and attach the following required documents:

☐ Copy of Designated Doctor Training Certificate(s) ☐ Copy of Designated Doctor Testing Certificate(s)

Mail the completed DWC Form-067, *Designated Doctor Certification Application*, and attachments to the following address or fax to (512) 804-4207:

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1645

Applicant's Name: Texas License #:	For TDI-DWC Use Only

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS 94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 490-1047 fax

Complete if known:
DWC Claim #
Carrier Claim #

Designated Doctor Examination Data Report

Extent of Injury, Disability, or Other Similar Issues

I. INJURED EMPLOYEE CLAIM INFORMATION

1. **Employee Name** (Last, First, Middle)	2. **Employee Social Security Number**
3. **Insurance Carrier Name**	4. **Date of Injury** (mm-dd-yyyy)

II. EXAMINATION INFORMATION

5. **Designated Doctor Name**	
6. **Designated Doctor Mailing Address** (Street or PO Box, City, State, Zip Code)	
7. **Designated Doctor License Number**	8. **Designated Doctor License Jurisdiction**
9. **Designated Doctor License Type**	10. **Designated Doctor Phone Number** ( )
11. **Examination Location** (Street, City, State, Zip Code)	
12. **Date and Time of Appointment**	

13. Does the claim involve medical benefits provided through a Certified Health Care Network?

☐ Yes ☐ No

If yes, provide the name of the network.

14. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool?

☐ Yes ☐ No

If yes, provide the name of the health care plan.

For TDI-DWC Use Only

III. DIAGNOSIS CODES FOR COMPENSABLE DIAGNOSES/CONDITIONS

15. Refer to the DWC Form-032 you received for this examination and provide below all the diagnoses/conditions listed in Section VII, Box 37. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each compensable diagnosis/condition listed. You may assign up to four diagnosis codes for each compensable diagnosis/condition. Attach additional pages, if necessary.

Compensable Diagnosis/Condition	For Data Purposes Only			
	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

IV. PURPOSE OF EXAMINATION

16. Issues considered during Designated Doctor's examination. Check only the items that were included on the DWC Form-032 and provide the requested information.

☐ **a) Extent of Injury**

Refer to the DWC Form-032 you received for this examination and provide below all the diagnoses/conditions listed in Section VIII, Box 42C. Did you determine that the accident or incident giving rise to the compensable injury was a substantial factor in bringing about the additional claimed diagnoses/conditions, and without it, the additional diagnoses/conditions would not have occurred? Provide your answer below by checking Yes or No for each additional claimed diagnosis/condition. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each additional claimed diagnosis/condition. You may assign up to four diagnosis codes for each additional claimed diagnosis/condition. Attach additional pages, if necessary.

Additional Claimed Diagnosis or Condition	Yes	No	For Data Purposes Only			
			Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)	☐	☐				
2)	☐	☐				
3)	☐	☐				
4)	☐	☐				
5)	☐	☐				
6)	☐	☐				
7)	☐	☐				
8)	☐	☐				

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

☐ **b) Disability - Direct Result**

Did you determine that the employee's inability to obtain and retain employment at wages equivalent to the pre-injury wage is a direct result of the compensable injury? ☐ Yes ☐ No

Refer to the DWC Form-032 you received for this examination and provide the following information as shown in Section VIII, Box 42D:

Provide the beginning and ending dates for the claimed periods of disability? If multiple periods, list all dates.
From _____ to _____ (mm/dd/yyyy)

☐ **c) Other Similar Issues**

Refer to the DWC Form-032 you received for the examination and describe the issue(s) listed in Section VIII, Box 42G, and provide your response to the issue(s).

V. REFERRALS / ADDITIONAL TESTING

17. Provide the requested information regarding referrals and additional testing for this examination.

Referral Health Care Provider Name	Provider License Number	Date of Service (mm/dd/yyyy)	Type of Testing						
			FCE	EMG / NCV	X-Ray	MRI	CT-Scan	Psychological Testing / Evaluation	Other
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

FCE (Functional Capacity Evaluation); EMG (Electromyography); NCV (Nerve Conduction Velocity); MRI (Magnetic Resonance Imaging); CT-Scan (Computed Tomography Scan)

VI. DESIGNATED DOCTOR'S SIGNATURE

18. Signature of Designated Doctor	19. Date of Signature (mm/dd/yyyy)

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

Frequently Asked Questions
Designated Doctor Examination Data Report
Extent of Injury, Disability, or Other Similar Issues (DWC Form-068)

Under what circumstances is the DWC Form-068 filed?
The DWC Form-068 must be filed when a designated doctor examination addresses issues of extent of injury, disability – direct result, or other similar issues. Do not file this form if the designated doctor examination only addressed issues of maximum medical improvement, impairment rating, and/or return to work.

Is a narrative report required when filing the DWC Form-068?
Yes. You must attach the narrative report required by 28 Texas Administrative Code §127.220, *Designated Doctor Narrative Reports.*

Where do I file the DWC Form-068?
The DWC Form-068, along with the narrative report, must be submitted as follows:

- Send to the treating doctor, TDI-DWC, and the insurance carrier by facsimile or electronic transmission.
- Send to the injured employee and the injured employee's representative (if any) by facsimile or electronic transmission if you have this information. Otherwise, you must send the reports by other verifiable means.

NOTE[1]: Title 28 Texas Administrative Code §127.220(c) requires a designated doctor who performs an examination under §127.10(f) to file a Designated Doctor Examination Data Report in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you: receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code §559.004).

DWC069

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 490-1047 fax

Complete if known:
DWC Claim #
Carrier Claim #

Report of Medical Evaluation

I. GENERAL INFORMATION

1. Workers' Compensation Insurance Carrier	4. Injured Employee's Name (First, Middle, Last)		9. Certifying Doctor's Name and License Type
	5. Date of Injury	6. Social Security Number	10. Certifying Doctor's License Number and Jurisdiction
2. Employer's Name	7. Employee's Phone Number		11. Certifying Doctor's Phone and Fax Numbers (Ph) (Fax)
3. Employer's Address (Street or PO Box, City State Zip)	8. Employee's Address (Street or PO Box, City State Zip)		12. Certifying Doctor's Address (Street or PO Box, City State Zip)

II. DOCTOR'S ROLE

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report [28 Texas Administrative Code (TAC) §130.1 governs such authorization]:

☐ Treating Doctor ☐ Doctor selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor selected by DWC
☐ Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI and/or permanent impairment after a Designated Doctor examination

NOTE: If you are not authorized by 28 TAC §130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

III. MEDICAL STATUS INFORMATION

14. Date of Exam	15. Diagnosis Codes
___/___/___	

16. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by DWC pursuant to Texas Labor Code §408.104.

a) ☐ Yes, I certify that the employee reached ☐ STATUTORY / ☐ CLINICAL **(mark one)** MMI on ____/____/_____ **(may not be a prospective date)** and have included documentation relating to this certification in **the attached narrative.** - OR -

b) ☐ No, I certify that the employee has **NOT** reached MMI but is expected to reach MMI on or about ____/____/_____ The reason the employee has not reached MMI is documented in **the attached narrative.**

NOTE: The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

IV. PERMANENT IMPAIRMENT

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☐ I certify that the employee does not have any permanent impairment as a result of the compensable injury. - OR -

b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is _____%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. **The attached narrative** provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the *Guides to the Evaluation of Permanent Impairment* published by the American Medical Association (AMA):
☐ third edition, second printing, February 1989 - OR -
☐ fourth edition, 1st, 2nd, 3rd, or 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000.

NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

V. DOCTOR'S CERTIFICATION

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required training and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and/or imprisonment and nullification of this report.

Signature of Certifying Doctor: _____ *Date of Certification:* _____

VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19. Treating Doctor's Name and License Type	22. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.
20. Treating Doctor's License Number and Jurisdiction	23. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no impairment. - OR - ☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.
21. Treating Doctor's Phone and Fax Numbers (Ph) (Fax)	

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: _____ *Date:* _____

Frequently Asked Questions
Report of Medical Evaluation (DWC Form-069)

INSTRUCTIONS FOR DOCTORS:

Who can file the DWC Form-069?

- ***Treating Doctor:*** Doctor chosen by the employee who is primarily responsible for employee's injury-related health care.
- ***Doctor Selected by Treating Doctor:*** Doctor selected by the treating doctor to evaluate permanent impairment and Maximum Medical Improvement (MMI). This doctor acts in the place of the treating doctor. Such a doctor must be selected if the treating doctor is not authorized to certify MMI or assign an impairment rating in those cases in which the employee has permanent impairment. An authorized treating doctor may also choose to select another doctor to perform the evaluation/certification.
- ***Designated Doctor:*** Doctor selected by the Texas Department of Insurance, Division of Workers' Compensation (DWC) to resolve a question over MMI or permanent impairment.
- ***Insurance Carrier-Selected RME Doctor:*** Doctor selected by the insurance carrier to evaluate MMI and/or permanent impairment. An insurance carrier-selected Required Medical Examination (RME) Doctor is only authorized to certify MMI, evaluate permanent impairment, and assign an impairment rating when specifically approved by DWC prior to the examination and only after a designated doctor has completed the same.

AUTHORIZATION: In addition to the requirement of acting in an eligible role, 28 Texas Administrative Code §130.1 provides the following requirements:

- ***Employee has permanent impairment:*** Only a doctor certified by DWC to assign impairment ratings or who receives specific permission by exception granted by DWC is authorized to certify MMI and to assign an impairment rating.
- ***Employee does not have permanent impairment:*** A doctor not certified or exempted from certification by DWC is only authorized to determine whether an employee has permanent impairment and, in the event that the employee has no impairment, certify MMI.

INVALID CERTIFICATION: Certification by a doctor who is not authorized is invalid.

Under what circumstances and when am I required to file the DWC Form-069?
If the employee has reached MMI, you must file the DWC Form-069 no later than the seventh working day after the later of: (a) date of the certifying examination; or (b) receipt of all medical information necessary to certify MMI. Only a Designated Doctor is subject to this requirement if the employee has not reached MMI.

Where do I file the form?
The DWC Form-069 and required narrative shall be filed with:

- the insurance carrier;
- the treating doctor (if a doctor other than the treating doctor files the report);
- DWC;
- injured employee; and
- injured employee's representative (if any).

The report must be filed by facsimile or electronic transmission unless an exception applies. The specific requirements are shown below. **To file this form with DWC, fax to (512) 490-1047.**

	Insurance Carrier	Treating Doctor DWC	Injured Employee Injured Employee's Representative
Designated Doctor	fax or e-mail	fax or e-mail	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means
Treating Doctor Doctor Selected by Treating Doctor Insurance Carrier-Selected RME Doctor	fax or e-mail	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means

Do I have to maintain documentation regarding the examination and report?
The certifying doctor must maintain the original copy of the report and narrative and documentation of the following:

- date of the examination;
- date any medical records necessary to make the certification of MMI were received, and from whom the medical records were received; and
- date, addresses, and means of delivery that required reports were transmitted or mailed by the certifying doctor.

Where can I find more information about the Report of Medical Evaluation?
See 28 TAC §130.1 through §130.4 and §130.6 for the complete requirements regarding the filing of this report, including required documentation. The complete text of these rules is available on the Texas Department of Insurance website at www.tdi.texas.gov/wc/rules/index.html. If you have additional questions, call 1-800-372-7713, Option #3.

IMPORTANT INFORMATION FOR INJURED EMPLOYEES:

What if I disagree with the doctor's certification of Maximum Medical Improvement (MMI) and/or permanent impairment rating for my workers' compensation claim?

If this is the first evaluation of your MMI and/or permanent impairment, you or your representative may dispute:

- the certification of MMI; and/or
- the assigned impairment rating.

To file the dispute, contact your local DWC field office or call 1-800-252-7031 to request:

- the appointment of a designated doctor (DD), if one has not been appointed; or
- a Benefit Review Conference (BRC).

Important Note: Your dispute must be filed **within 90 days** after the written notice is delivered to you or the certification of MMI and/or the assigned impairment rating may become final.

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have DWC correct information that is incorrect (Government Code, §559.004).

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree		(for transmission purposes only)	Date Being Sent
1. Injured Employee's Name	6. Clinic/Facility Name		9. Employer's Name
2. Date of Injury / 3. Social Security Number (last 4) xxx-xx-	7. Clinic/Facility/Doctor Phone & Fax		10. Employer's Fax # or Email Address (if known)
4. Employee's Description of Injury/Accident	8. Clinic/Facility/Doctor Address (street address)		11. Insurance Carrier
	City State Zip		12. Carrier's Fax # or Email Address (if known)

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee to return to work as of _____ (date) **without restrictions**.

☐ (b) will allow the employee to return to work as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury prevents the employee from returning to work:

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):		17. MOTION RESTRICTIONS (if any):		19. MISC. RESTRICTIONS (if any):
Max Hours per day: 0 2 4 6 8	Other	Max Hours per day: 0 2 4 6 8	Other	☐ Max hours per day of work: _____
Standing ☐☐☐☐☐		Walking ☐☐☐☐☐		☐ Sit/Stretch breaks of _____ per _____
Sitting ☐☐☐☐☐		Climbing stairs/ladders ☐☐☐☐☐		☐ Must wear splint/cast at work
Kneeling/Squatting ☐☐☐☐☐		Grasping/Squeezing ☐☐☐☐☐		☐ Must use crutches at all times
Bending/Stooping ☐☐☐☐☐		Wrist flexion/extension ☐☐☐☐☐		☐ No driving/operating heavy equipment
Pushing/Pulling ☐☐☐☐☐		Reaching ☐☐☐☐☐		☐ Can only drive automatic transmission
Twisting ☐☐☐☐☐		Overhead Reaching ☐☐☐☐☐		☐ No work / _____ hours/day work: ☐ in extreme hot/cold environments ☐ at heights or on scaffolding
Other: ☐☐☐☐☐		Keyboarding ☐☐☐☐☐		☐ Must keep _____ ☐ elevated ☐ clean & dry

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Left Leg
☐ Right Hand/Wrist ☐ Right Leg
☐ Left Arm ☐ Back
☐ Right Arm ☐ Left Foot/Ankle
☐ Neck ☐ Right Foot/Ankle

Other:

Other:

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day

☐ May not perform any lifting/carrying

Other:

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No running

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)

☐ Advised to take over-the-counter meds

☐ Medication may make drowsy (possible safety/driving issues)

16. OTHER RESTRICTIONS (if any):

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm

☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm

☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm

☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm

☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

Frequently Asked Questions
Work Status Report (DWC Form-073)

Under what circumstances am I required to file the DWC Form-073?
Filing requirements for DWC Form-073 vary depending on the type of doctor filing the Work Status Report. The specific requirements are shown in the chart below.

Type of Doctor	When to File DWC Form-073	Where to File	Delivery Method	Deadline
Treating Doctor ***or*** ***Referral Doctor***	• after the initial examination of the injured employee, regardless of the employee's work status • when there is a change in the injured employee's work status • when there is a substantial change in the injured employee's activity restrictions • on a schedule requested by the insurance carrier as long as it is based on the injured employee's scheduled appointments with the doctor (not to exceed one report every two weeks)	• injured employee	hand deliver	at the time of the examination
		• insurance carrier	fax or e-mail	within 2 working days of the examination
		• employer	fax or e-mail unless recipient has not provided these numbers; then by personal delivery or mail	
	• after receiving a set of functional job descriptions, from the employer or insurance carrier listing modified duty positions, including the physical and time requirements of the positions, that the employer has available for the injured employee to work • after receiving a DWC Form-073 from a RME Doctor that indicates the injured employee is able to return to work with or without restrictions	• injured employee	hand deliver unless no appointment is scheduled before deadline; then fax or e-mail unless recipient has not provided these numbers; then by mail	within 7 days of receiving job description or RME opinion
		• insurance carrier • employer	fax or e-mail	
Designated Doctor	• after examination of an injured employee to address any question relating to return to work **NOTE:** The Designated Doctor must file a narrative report along with the DWC Form-073.	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 working days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
		• TDI-DWC	fax to 512-490-1047	
RME Doctor selected by insurance carrier	• after examination of an injured employee (subsequent to a Designated Doctor's examination), if the RME doctor determines that the injured employee can return to work immediately with or without restrictions	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
RME Doctor selected by DWC	Not applicable. TDI-DWC's medical examinations are ordered in accordance with §408.0041, Texas Labor Code, and applicable Division of Workers' Compensation rules.			

Where can I find more information about the DWC Form-073?
For complete requirements regarding the filing of this report, see 28 TAC §§126.6, 127.10, and 129.5. These rules are available on the TDI website at www.tdi.texas.gov/wc/rules/index.html. If you have additional questions, call *Comp Connection for Health Care Providers* at 1-800-372-7713 (804-4000 in the Austin area) and select option 3.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).